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Orchard Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the Service
Orchard Lodge provides nursing care and accommodation for older people, many of whom are living with life limiting conditions. The premises is a purpose built building with two floors. The service is registered to provide care for up to 28 adults. At the time of the inspection 13 people were living there.

People's experience of using this service and what we found
People were not protected from the risk of harm because care plans and risk assessments were not amended when their needs had changed, and staff did not always follow guidance that was in place. People were not protected from infection because parts of the service were not clean or in good repair, and staff did not follow good practice guidance on reducing the risk of infections.

People were at risk of receiving inadequate nutrition because information about their requirements was not effectively shared with kitchen staff. Monitoring systems were not used effectively to identify causes of unusual weight loss or gain.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff were kind, but engagement with people was task based. Many people spent most of their day alone as they were cared for in bed and only saw staff when they needed support, such as at mealtime or with personal care. This put them at risk of isolation. The garden and some parts of the premises were in disrepair. This was not a safe and dignified environment for people to live in.

Activities offered did not always meet people's preferences and choices. Activity records showed that a range of activities took place, but these were mostly not provided in response to people's personal interests.

The provider did not model good practice or promote person centred care. Some improvements to the service had been made since the last inspection. However, progress towards making the required improvements was slow and quality monitoring systems were not effective. The continued multiple breaches found indicated that people were not receiving good care that considered their individual needs and preferences, and the right to a good quality of life.

The provider was in breach of a condition imposed on their registration and in doing so demonstrated they either did not understand or they intentionally failed to fulfil their regulatory responsibilities demonstrated a failure to understand their regulatory responsibilities.

Staff understood their responsibilities to protect people from the risk of abuse. Staff received training and supervision to support them to carry out their duties. There was a system in place for managing and

monitoring complaints.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update
The last rating for this service was Inadequate (report published 08 May 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. It was also carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to safety and managing risk, infection control, support in relation to nutrition, person centred care, and the overall management oversight of the service and a breach of a condition of the provider's registration, at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Orchard Lodge Care Home

Detailed findings

Background to this inspection

The Inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team was made up of three inspectors.

Service and service type
Orchard Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is required to have a registered manager. The service had a new manager who was not registered with the Care Quality Commission yet. This means that the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided. The report will therefore refer to 'the manager', rather than 'the registered manager'.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed information we hold about the service as part of our ongoing monitoring. This included weekly action plan updates submitted by the provider, information about any reportable incidents they had sent to us, and regular feedback from the local authority about the service. We used all of this information to plan our inspection.

During the inspection
Many of the people using the service were unable to tell us about their experiences of the service in detail. Therefore, we observed care, both informally and by using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people and two relatives. We also spoke with three care staff, kitchen staff, a nurse, the manager, the provider's representative and the provider.

We reviewed a range of records. This included ten people's care records and three medication records. We looked at two staff files in relation to recruitment and staff supervision, and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
After the inspection the provider sent us more information for review, including information on action taken since the inspection, and activity records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection the rating for this key question has remained the same.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection
At the last inspection care plans and risk assessments were not sufficiently detailed to ensure that people were protected from harm. The heating and hot water supply had failed, leaving people exposed to the risk of cold temperatures and the spread of infection, in particular, legionella. Care monitoring records were not consistently or accurately completed, and medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

● Although some improvements had been made to care plans and risk assessments, we identified gaps and inaccuracies that put people at risk of harm. For example, there was no care plan or risk assessment relating to choking for one person known to be at risk. The same person's care plan showed them to have no breathing difficulties, although they had recently been prescribed an inhaler because they had experienced shortness of breath.
● Staff did not always follow the care plans when delivering care. For example, one person's care plan stated they required support to eat and that staff should ensure the person was sitting upright. On the day of the inspection we observed that the person was lying down, while attempting to eat with no support. They had dropped the spoon and were making hand movements from their bowl to their mouth, but not eating any food. This person was assessed to be at risk of losing weight. The lack of support by staff had the potential to increase this risk.
● People were at risk of infection because the environment was not sufficiently maintained or cleaned, and staff did not follow good practice in relation to cleanliness and infection control.
● Two bathrooms were in disrepair. In the first there were tiles missing from the wall near the toilet and in the second, the floor was worn and stained, paintwork was cracked, flooring was worn and stained and there was unidentified brown matter on the walls and shower cubicle. Both of these bathrooms were in regular use.
● In a bathroom drawer we found a used toothbrush and toothpaste stored alongside a box containing human nail clippings.
● A prescribed cream found in use in a person's bedroom was contaminated with what looked like human skin.
● There was no protocol in place for one person's inhaler prescribed on an 'as required' basis. This meant

staff did not have sufficient guidance on when it was appropriate to administer this medicine.
● Some prescribed creams stored in people's bedrooms had no date of opening, and in two instances were out of date. First aid equipment in the dining room was also out of date.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● We spoke with the manager who confirmed that new first aid equipment had been ordered and this was put in place during the inspection.
● Other medicines were stored securely and dates of opening were clearly recorded.
● A sample of medicine stock was reviewed and checked against records. The records we looked at were correct.
● Medicine administration records were accurately kept, with no unexplained gaps.

Staffing and recruitment
● We looked at the recruitment records for two staff employed after the last inspection and found that some pre-employment checks required by the regulations had not been completed.
● Both of the employees did not have a full employment history which included an explanation of any gaps in employment. There were no interview notes kept to show whether or not this had been explored at interview.
● When asked about this the provider's representative told us that there was no formal interview process in place and a record had not been made of how the decision to employ both people had been reached.
● The provider's representative showed us an action plan which had been produced following an audit by a third party, detailing the above issues and with a timeframe for making improvements.

Systems and processes to safeguard people from the risk of abuse
At the last inspection, staff did not have a good understanding of their responsibility to protect people from the risk of harm or abuse or of how to report any concerns they had. This meant the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation13.

● Staff understood what to do to make sure people were protected from harm or abuse.
● They knew how to report any concerns they had both internally and to other bodies such as the local authority and the Care Quality Commission.

Learning lessons when things go wrong
● The provider had a system to record incidents or accidents.
● We still found failures and shortfalls at this service. Therefore we were not confident lessons had been learnt following the last two inspections.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection the rating for this key question has deteriorated to 'inadequate'.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet; staff working with other agencies to provide consistent, effective, timely care

- People did not always receive a diet appropriate to their needs, which put them at risk of not eating well. We identified three people assessed as needing a fortified diet who did not receive this on the day of the inspection. This was because their change in needs had not been communicated to the kitchen staff, who therefore, had not updated their records.
- Records showed that each of these people had lost weight in recent months, although it was not confirmed how much because the new weighing scales used at the service were providing different readings from the old ones. This meant that either the old or the new scales were incorrect. This had not been identified by the provider until it was pointed out by a visiting professional on the day of the inspection. Until it was established which scales were giving correct readings, people were at risk of receiving inappropriate care, such as pressure relieving mattresses being set to the wrong weight or not being referred to a dietitian when needed.
- There was inconsistent information across one person's records in relation to their dietary requirement. Some records stated they needed a soft diet, and another stated a fork mashable diet was suitable for them. This person received a regular meal which was mashed up by a member of staff when this was pointed out to them by an inspector. The meal had been sitting on a trolley for 37 minutes before it was served and was very likely to be cold by the time the person was given it. The person did not eat most of their meal.
- A referral to the speech and language therapy (SALT) team assessed as necessary by a GP in March 2019 had not been followed up by nursing staff. Although staff told us the referral was made, there was no record of this. As a result of this omission, no action had been taken to ensure this person could eat and drink safely without choking.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When this was discussed with the manager they took immediate action to contact the GP and follow up the referral to the SALT team. The GP took action to reduce the risk to the person while they waited for the appointment to be arranged.

Adapting service, design, decoration to meet people's needs

- The premises and grounds were not maintained to an acceptable standard and sufficient improvement to

some areas had not been made since the last inspection.
● Two bathrooms were not maintained or clean and therefore not fit for purpose. Following our inspection these bathrooms were put out of use for repair work to be completed.
● Work needed to ensure a sustainable solution to the heating and hot water problems identified at the last inspection in December 2018 had still not taken place. It had been agreed with the Care Quality Commission this could be put off until the weather was warmer as it required the whole system to be shut down for the duration of the work.
● We were advised by the provider's representative that the work was due to happen on 12th August 2019. Because of this delay, some areas of the home were now too warm because some radiators could not be turned off. This put people's health and wellbeing at risk. This demonstrated the provider's failure to make the necessary repairs as planned.
● The carpet in one person's room was ripped, creating a trip hazard for both the person and staff.
● People did not have safe access to the garden because it was in disrepair. Ramps were uneven, fencing was broken and benches were rusted. A relative told us, "The building is tatty and the garden is unusable, with no seating. I would love to be able to take [family member] out in the garden when I visit and get her some fresh air but the seating is dirty and rusty."

These issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the last comprehensive inspection in December 2018, the provider had made improvements to other parts of the building. This included redecoration of communal spaces and some bedrooms, and some repairs and replacements that were required such as a new fire door.
● Some signage had been provided to support people who live with dementia to find their way around the building.
● Following this inspection, the provider immediately took the two bathrooms out of service for refurbishment.

Supporting people to live healthier lives, access healthcare services and support
● The service worked with other healthcare providers to meet the health-related needs of people who used the service.
● We saw from records that people had support to access health care from community health professionals such as a GP. However, although advice from professionals was recorded in documents under visit records, this information was not always used to update care plans or risk assessments. This meant that people were at risk of receiving inappropriate care.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection in December 2018, the provider was in breach or Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no evidence to suggest how decisions were made in people's best interests when they lacked the capacity to make the decision themselves. Staff, including the management team did not recognise when it was necessary to make decisions in a formal way to demonstrate how their actions were in the person's best interests. Records of consent to various aspects of care were signed by relatives on behalf of people, although there was no record to indicate that the relative had legal powers, such as the power of attorney for health and welfare, which allowed them to give this consent.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 11.

● Where considered necessary by the provider, care plans now stated when a decision was being made in the person's best interests. However, there was no evidence to show how or why this decision had been made, or who had been involved.
● Three people were assessed as requiring a DoLS authorisation although the current DoLS for one of these people had expired. When asked, the manager was not able to give a clear answer as to whether anyone else at the service required a DoLS authorisation to be applied for. However, they confirmed that should most people attempt to leave the premises without staff, they would be brought back or staff would go with them. This suggested that more people might need DOLS authorisations as they are not free to leave and are under constant supervision.
● Records of consent for various aspects of care continued to be signed by relatives on behalf of people, whether or not they had been assessed to lack capacity.
● There was no record to state the person had delegated this responsibility to their relative. Relatives did not all have the necessary legal powers to give consent on behalf of their family member without their expressed agreement.

These issues are a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Following the last inspection, we imposed a condition on the provider's registration to prevent new admissions to the service without our written consent. Except for one admission in breach of this condition, the service had not admitted anyone new into the service. Therefore, we could not follow up on the evidence we saw at the last inspection.
● The provider had a pre-admission assessment process in place that was in line with legislation and up to date guidance. However, assessments were not always completed thoroughly to ensure the care provided was person centred.
● As part of the process of rewriting care plans, we saw that staff knowledge of people's preferences was being more effectively recorded.

Staff support: induction, training, skills and experience
● Staff told us they received training to support them to carry out their duties. Records confirmed this, and training for most staff was within date or planned for the very near future.
● The new manager had enrolled on several 'train the trainer' courses to enable them to deliver essential

training to staff on an ongoing basis.
- Staff confirmed they received supervision.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection the rating for this key question has remained the same.

This meant people were not always well-supported, cared for or treated with dignity and respect.

At the last inspection the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This was because staff did not engage with people beyond providing care and support, and were not visible throughout the service. This left people isolated and in some instances, in distress. The environment did not demonstrate that people were cared for and did not uphold their dignity. Staff, including managers used disrespectful language to describe people, and confidential records were not stored securely.

At this inspection, although we found some improvements and the service is no longer in breach of Regulation 10, more work was needed to ensure people received good and compassionate care.

Ensuring people are well treated and supported; respecting equality and diversity

- There remained a lack of respect for the fact that Orchard Lodge is people's home.This was demonstrated by the provider's and their representative's actions on the day of the inspection, as well as by their failure to identify and address issues with the maintenance of the premises, gardens and equipment.
- On the afternoon of the inspection, the provider sat in the lounge where a person was present and spoke to a third party on their mobile phone for a considerable length of time. Inspectors walked past this area several times over the course of over half an hour and noted this. Although they may have been talking with the person at other times, it was disrespectful to carry out their private conversations in the person's sitting room.
- The provider's representative also stood for some time talking with a professional visitor, again in front of the person who was in their lounge.
- Staff were more visible in the home, but still did not engage with people much beyond the support they provided and brief chats. There were many missed opportunities for staff to engage meaningfully with people, but we observed they were often silent even when providing support. For example, an inspector observed one person being supported to eat their lunch in their room. The member of staff provided this support in silence, without offering any encouragement or making any conversation.
- The provider and the manager strongly refuted that staff did not engage effectively with people and told us they frequently witnessed staff chatting to people. Unfortunately, our observations on the day found engagement was minimal and interaction, although positive, was brief and task based
- The manager told us that a religious service was provided regularly for people to attend. However, when we asked which faith this service was for they told us it was "Just a general Christian one." They were unable to tell us about the spiritual or religious needs of people who used the service, except about one person

whose family provided support in relation to this.

● People and their relatives told us that staff were kind but one person said, "Yes they are nice but there's not much chat." A relative said, "[Name of Nurse] is lovely."

● Staff we spoke with did not show an understanding that talking to people beyond providing care related support was part of their job. They saw this type of engagement as part of the activity staff's role. This meant that one part time member of staff bore the responsibility of supporting the social and psychological wellbeing of all the people living at the service.

Supporting people to express their views and be involved in making decisions about their care

● People's views were not always respected by staff. For example, when an offered activity was refused by people, it continued anyway. Also, when a person wanted to go to bed, a staff member did not listen or ask them why, but they told the person they should stay up.

Respecting and promoting people's privacy, dignity and independence

● Staff supported people to maintain their privacy and dignity when assisting them with personal care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection the rating for this key question has now improved to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At the last inspection in December 2018 care plans and risks assessments were inadequate and task centred, failing to identify the individual needs and preferences of people using the service. Many care plans were handwritten and not legible. Reviews of care plans were not effective. Staff practice reflected these care plans and was task centred, focussed only on the physical needs of people. People's individual needs and preferences were not considered adequately in the delivery of care. Many people were cared for in bed and had little to no contact with staff for long periods.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● Revised care plans were in place but were not meaningfully reviewed. Monthly reviews were one sentence entries stating no change had occurred, in most instances. Where people's needs had changed it was not recorded. For example, the care plan and risk assessment for one person whose needs had changed in relation to choking had not been updated to reflect this since March 2019.
● One person repeatedly requested to go to bed in the late morning. A member of staff repeatedly told them to wait until after lunch. There was no consideration given to making an alternative arrangement to enable the person to rest, such as having lunch later after they had rested. Eventually a second member of staff responded positively to the person's request and they went to lie down.
● A second person had been unwell and had refused food and drink all day. At 8.45am when we arrived, the person was already sitting in a chair in the lounge. At 4pm, they were still sitting in the same position. It was noted by an inspector that the person had not been offered any personal care support all day and records confirmed this. Staff then asked if they wanted support which they declined. Although this person was unwell and this had gone on all day, no action was taken to bring forward a planned GP appointment and no consideration was given as to whether the person may be dehydrated.

These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans had been rewritten and now contained more personalised information.
● Although still handwritten, care plans now were legible, and where staff's handwriting was difficult to read, the manager had directed them to write in capital letters to improve this.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

At the last inspection in December 2018, we found that staff engagement and interaction was poor and people were at risk of isolation, spending many hours on their own, particularly those people cared for in bed. There was little planned or meaningful activities offered to people to occupy their time. This was also a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9 in relation to this.

● Staff engaged with people to provide care and support such as bringing them a meal or to make brief friendly remarks in passing. However, there was little interaction beyond this.
● We observed one person eating lunch alone in the dining room for forty minutes. No staff approached them in this time and just carried on with the task of dishing up and taking meals to people eating in their rooms, making noise and talking to each other.
● The three people who were in the communal lounge in the morning were offered a singing activity. Two out of the three people refused this, one of them firmly, but the activity went ahead anyway. This interfered with one person's enjoyment of a television programme they were watching at the time. There was no evidence that this activity had been planned in response to these people's preferences.
● The ten people cared for in their rooms on the day of the inspection did not have sufficient engagement from staff and spent many hours alone, with nothing to do and no company other than, in some instances, a television or music.
● The garden was in disrepair and not safe for use which had been the case for many months. This meant that one person who really enjoyed gardens and wildlife was not able to safely follow their interests.
● We discussed the lack of engagement and meaningful occupation with the provider and the manager who strongly refuted this as they felt greater improvement in this area had been made.
● Following the inspection, they provided activities records which we reviewed. It was clear that some activities were being provided by the service. However, these records had been completed inaccurately for the day of the inspection for one person, indicating their participation, which had not occurred.
● Many recorded activities were in relation to watching television or listening to the radio. Many others were generic, such as nail care, hand massage, singing and there was little evidence that people's personal interests had been consistently taken into account.

These issues were also a continued breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Some people's care plans made reference to using pictures to support communication. However, this was

not seen in practice on the day of the inspection.
● A volunteer who had been working with one person had recorded how responsive the person was to photographs and pictures. However, this information had not been used to create better opportunities for the person to communicate with staff.
● Systems within the home had not been developed in line with accessible format standards. For example, menus were not presented in a pictorial format to help people understand what was on offer each day.

End of life care and support
● At the last inspection in December 2018, end of life plans had not been developed for most people who used the service. This was a particular concern because many people using the service were either receiving end of life care or were very unwell.
● At this inspection we found that end of life plans had been included in people's revised care plans.
● These included important information in relation to their care needs, but needed further work to include personalised care in relation to their wishes for the final weeks and days of their life.

Improving care quality in response to complaints or concerns
At the last inspection in December 2018, the service was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider did not have a formal system for logging complaints. Where there was evidence that complaints had been received and managed, the responses to these were dismissive and not used to make improvements to the service. People and their relatives reported that their complaints were not taken seriously.

At this inspection we found improvements had been made and the service was no longer in breach of Regulation 16.

● The provider now had a system for recording complaints and this was used to check the types of complaints received and to help the manager to investigate these.
● People and their relatives told us they knew how to make a complaint and were more confident that the manager would take action to deal with their concerns.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection the rating for this key question has remained the same.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection in December 2018, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were multiple breaches of regulations, poor management oversight in relation to the environment and the delivery of care, poor staff deployment, inadequate record keeping and a lack of understanding of person-centred care leading to a task led culture within the service.

Not enough improvement has been made and the provider is still in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The task-centred culture of the service remained embedded and the provider was not promoting a person-centred culture.
- There was a failure to respond to changing and new needs of people. This was demonstrated by the failure to update care plans, make or follow up referrals to health professionals and manage risks in the interim.
- The failure to identify and address issues with the maintenance of the premises, gardens and equipment showed the provider did not ensure people were provided with a safe dignified environment to live in.
- The provider did not model good practice to staff in relation to how people should be treated in their own home.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The manager is new to the service and had not begun the process to register with the commission at the time of the inspection.
- Audits and monitoring systems in place at the service were not being used effectively to ensure good quality and safe care was provided to people. Information gathered through audits did not provide enough detail to be of use in improving the quality of the service.
- For example, an infection control audit identified infections observed in the home in each month. Each entry was just a number, such as 8, 3, or 2. It did not state what type of infection, whether it was one person with multiple infections or several people each with one infection. The potential causes of, and the action taken in each of these cases would be different, but as such, the audit did not provide any useful information

and was not fit for purpose.
● Audits had not been used to identify or support action to address issues identified at the inspection. This was in relation to widespread issues, such as gaps and inconsistencies in care plans and risk assessments, maintenance issues in relation to the premises and the garden, infection control and the maintenance of equipment.
● Although monitoring charts were now being kept, they were not monitored effectively to ensure they were accurate and to raise questions about any anomalies that occurred. For example, the recent discrepancies in people's weights had not triggered a management investigation into potential reasons for this. This put people at risk of receiving inappropriate or unsafe care.
● Despite ongoing support from the local authority and other partner professionals, the provider demonstrated a lack of proactive action to make the improvements required since the inspection in December 2018. They had relied on external professionals to identify shortfalls in the service and had not made sufficient improvements in the eight months since first being rated inadequate in December 2018.
● The provider demonstrated a lack of understanding about of what good care, and the processes that underpin it, should look like. This shortfall was reflected during the inspection feedback session where inspectors had to repeatedly explain the basic principles of good care to the provider, despite their many years in the care industry.
● The provider had complied with a condition imposed on their registration that they would submit a weekly report to the Care Quality Commission on the progress of the action plan following the last inspection. However, we found that progress towards making sufficient improvements had been slower than hoped. Although many issues had been recorded as addressed the standard of the improvements made was not always sufficient.

All of these issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the last inspection, we imposed a condition on the provider's registration to restrict new admissions without our written consent. On 30th July, the provider breached this condition by admitting one person. This demonstrated the provider either failed to understand, or intentionally failed to fulfil their regulatory responsibilities.

This was a breach of the providers conditions under section 33 of the Health and Social Care Act 2008

At the last inspection the provider was in breach of Regulation 20a of the Health and Social Care Act because they had failed to display their most recent rating as required by this legislation.

At this inspection improvements were made and the provider was no longer in breach of Regulation 20a.

At the last inspection the provider was in breach of Regulation 18 of the Care Quality Commission (registration) Regulations because they had failed to notify us of reportable incidents as required by this legislation.

At this inspection improvements were made and the provider was no longer in breach of Regulation 18.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Working in partnership with others
● The provider did not always promote a culture of openness and transparency about the performance of

the service.
● The provider requested the names of staff who had shortfalls in their practice rather than address concerns as a service wide issue to be dealt with by the whole team. This did not encourage an open and honest culture to develop within the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems were in place to involve people and staff in giving feedback about the service.
● Records of staff meetings showed these took place and were used to inform staff of issues and to seek their views.
● Meetings for people living at the service were held, although these were mostly attended by relatives on people's behalf as many people were cared for in bed.
● A recent satisfaction survey had been completed, seeking people's views of the service.